CHRONOLOGICAL RECORD OF MEDICAL CARE

64848

Smallpox Vaccination Initial Note Page 1 (2-Page Format)

This page may be completed by potential vaccine recipient

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

1. Today's Date (M M / D D / Y Y Y Y) ☐☐ / ☐☐ / ☐☐☐☐

2. GENDER ○ Male ○ Female

2a. FEMALES: Was your last menstrual period normal and on time? ○ Yes ○ No ○ Unsure

2b. Are you currently breastfeeding? ○ Yes ○ No

3. Could someone you LIVE WITH or YOU be pregnant?	○ Yes	○ No	○ Unsure
4. Did you ever receive smallpox vaccine?	○ Yes	○ No	○ Unsure
4a. IF YES: Were you vaccinated within the last 10 years?	○ Yes	○ No	○ Unsure
4b. IF UNSURE: Birth Year ☐☐☐☐ First Year in Military (if applicable) ☐☐☐☐			
5. Have you ever had a serious problem after smallpox or other vaccination? (Describe below)	○ Yes	○ No	○ Unsure
6. Do you currently have an illness with fever?	○ Yes	○ No	○ Unsure
7. Are you allergic to any of these products: tetracycline, streptomycin, polymyxin B, neomycin, latex?	○ Yes	○ No	○ Unsure
8. Do you NOW HAVE or have you EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.)	○ Yes	○ No	○ Unsure
9. Do you NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease, Other Skin Condition (Describe below)?	○ Yes	○ No	○ Unsure
10. Do you have a problem or take a medication that affects the immune system? For example, do you have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem; have or take medication for Crohn's disease, lupus, arthritis, or other immune disease; have had radiation or X-ray treatment (not routine X-rays) within the last 3 months; have EVER had a bone-marrow or organ transplant (or take medication for that); or have another problem that requires steroids, prednisone or a cancer drug for treatment.	○ Yes	○ No	○ Unsure
11. Do you LIVE WITH anyone who NOW HAS or EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.)	○ Yes	○ No	○ Unsure
12. Do you LIVE WITH anyone who NOW HAS any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease, Other Skin Condition (Describe below)?	○ Yes	○ No	○ Unsure
13. Do you LIVE WITH someone who has a problem or takes a medication that affects the immune system? For example do you have a close household contact who has or takes medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem; has or takes medication for Crohn's disease, lupus, arthritis, or other immune disease; has had radiation or X-ray treatment (not routine X-rays) within the last 3 months; has EVER had a bone-marrow or organ transplant (or take medication for that); or has another problem that requires steroids, prednisone or a cancer drug for treatment.	○ Yes	○ No	○ Unsure
14. Do you other questions or have other concerns you would like to discuss?	○ Yes	○ No	

NOTE: If you think you might have one of the many risk factors for HIV infection, we can arrange for HIV testing before vaccination.
FOR FEMALES: If you think you might be pregnant, you should get a pregnancy test before vaccination. Please tell us.

Explain "other", "unsure" or additional concerns (may use additional page)

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use for mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPART./SER

64848

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 2 (2-Page Format)

This page to be completed by a health care provider

1. Provider Assessment Date (MM/DD/YYYY) If Provider Assessment Date or Action Taken Immunization Date is blank, Default is "Today's date" on page 1.

☐☐ / ☐☐ / ☐☐☐☐

2. Reason for Vaccination (Indicate One):

○ Pre-outbreak: disease prevention

○ Post-outbreak: not exposed to virus

○ Post-outbreak: exposed to virus

○ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and additional interview if needed (Check all that apply):

	Self	Close contact
No risk factors	☐	☐
Pregnancy	☐	☐
Immune supression	☐	☐
Skin condition	☐	☐
Relevant allergy	☐	
Unsure/other risk	☐	☐ (Describe)

Refer to skin condition assessment tool for clinical evaluation guidance

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevent diagnosis

5. Provider Decision and Plan (Check all that apply):

☐ Vaccinate: Primary (e.g. birth year>1972, military entry >1984)

☐ Vaccinate: Revaccination

☐ Medically immune: vaccinated within approp interval (MI)

☐ Vaccination deferred: Pending consult or lab test

☐ Vaccination deferred: Temporary contraindication (MT)

☐ Vaccination contraindicated unless exposed (MP)

☐ Vaccination not given (other reason specify below):

6. IF NOT IMMUNIZED, Check all that apply:

☐ Reason for non-immunization explained

☐ Lab test requested

☐ Consult request written/sent

☐ Follow up appointment planned

☐ Other reason (specify below):

List labs or consults requested, and length of temp referrals

Provider Signature and Printed Name/Stamp:

VACCINE ADMINISTRATION:

Vaccination Date (M M / D D / Y Y Y Y)

7. Vaccination Action Taken: ☐☐ / ☐☐ / ☐☐☐☐

Location: ○ Left Arm ○ Right Arm ○ Other location (describe)

Number of Jabs: ☐☐

Default Lot # is 4020071, Mfr is WAL (Wyeth Ayerst Laboratories)
IF Lot # and/or Mfr are different, specify below:

Lot # ☐☐☐☐☐☐☐ Mfr ☐☐☐

For QA use: local vial serial # ☐☐☐

8. IF IMMUNIZED, Check all that apply:

☐ Information sheet given to recipient

☐ Recipient advised about post-vaccination reaction and care

☐ Reasons for follow-up clinic visit described

☐ Patient understands information given

☐ Bandages provided if needed

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Vaccine administered by: (Signature and Printed Name/Stamp)

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use for mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
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